General Intake Form

** indicates a required field*

*** Today's Date**

*** Service**

- [ ] Individual Therapy
- [ ] Couples Therapy
- [ ] Pre-Marital Preparation
- [ ] Spiritual Direction
- [ ] Consultation
- [ ] Coaching
- [ ] Other

*** Your Name**

*** Birthdate**

*** Pronouns**

*** Gender - Choose as many as apply**

- [ ] Female
- [ ] Male
- [ ] Nonbinary/Non-conforming
- [ ] Transgender
- [ ] Genderqueer
- [ ] Self-described definition

*** Address**

*** Phone Number (best for messages/texts)**

*** Email**

*** Emergency Contact: Name, Phone, and Relationship to you**

HEALTH

*** How is your physical health at present?**

- [ ] Poor
- [ ] Unsatisfactory
- [ ] Satisfactory
- [ ] Good
- [ ] Very Good

*** Specify all medications and supplements you are presently taking and for what reason.**

If taking prescription medication, who is your prescribing MD? Please include type of MD, name and phone number.

*** Who is your primary care physician? Please include type of MD, name and phone number.**

*** Have you seen a mental health professional before?**

- ( ) Yes
- ( ) No

*** Have you ever been hospitalized for a physical illness?**

- Yes
- No

*** Have you ever been hospitalized for a psychiatric issue?**

- Yes
- No

*** Is there a history of mental illness in your family?**

- Yes
- No

*** Do you have thoughts or urges to harm others?**

- Yes
- No

*** Do you have suicidal thoughts?**

- Yes
- No

*** Have you ever attempted suicide?**

- Yes
- No

*** Do you use recreational drugs?**

- Yes
- No

*** Please check any of the following that apply**

- [ ] Headache
- [ ] High blood pressure
- [ ] Gastritis or esophagitis
- [ ] Hormone-related problems
- [ ] Head injury
- [ ] Angina or chest pain
- [ ] Irritable bowel
- [ ] Chronic pain
- [ ] Loss of consciousness
- [ ] Heart attack
- [ ] Bone or joint problems
- [ ] Seizures
- [ ] Kidney-related issues
- [ ] Chronic fatigue
- [ ] Dizziness
- [ ] Faintness
- [ ] Heart valve problems
- [ ] Urinary tract problems
- [ ] Fibromyalgia
- [ ] Numbness & tingling
- [ ] Shortness of breath
- [ ] Diabetes
- [ ] Hepatitis
- [ ] Asthma
- [ ] Arthritis
- [ ] Thyroid issues
- [ ] HIV/AIDS
- [ ] Cancer
- [ ] Other

*** Do you drink alcohol?**

- ○ Yes
- ○ No

*** Do you smoke?**

- ○ Yes
- ○ No

*** Please check any of the following you have experienced in the past six months**

- ☐ Increased appetite
- ☐ Decreased appetite
- ☐ Trouble concentrating
- ☐ Difficulty sleeping
- ☐ Excessive sleep
- ☐ Low motivation
- ☐ Isolation from others
- ☐ Fatigue/low energy
- ☐ Low self-esteem
- ☐ Depressed mood
- ☐ Tearful or crying spells
- ☐ Anxiety
- ☐ Fear
- ☐ Hopelessness
- ☐ Panic
- ☐ Other

*** In the past year, have you experienced any significant life changes or stressors?**

WORK HISTORY

*** What is your level of education? Highest grade/degree and type of degree.**

*** What is your current occupation? What do you do? How long have you been doing it?**

If presently unemployed, please describe the situation.

*** Are you happy in your current position?**

- Yes
- No

Please list any work-related stressors, if any.

*** What are your hobbies/avocations?**

FAMILY SYSTEMS INFORMATION

*** Describe your current living situation. Do you live alone, with others. With family, etc...**

*** If you are in a relationship, please describe the nature of the relationship and months or years together.**

Partner's name

On a scale of 1-10, how would you rate the quality of your current relationship? (1 being the worst and 10 being the best)

- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4
- [ ] 5
- [ ] 6
- [ ] 7
- [ ] 8
- [ ] 9
- [ ] 10

If you have children, please list them in chronological order (oldest to youngest) and their age and gender identity. Please include abortions (A), miscarriages (MC), and stillbirths (SB). Ex. Male 17, Non-binary 15, MC, MC, MC, SB, and Female 6.

Did you go through fertility treatments and/or adoption to build your family?

- ( ) Yes
- ( ) No

*** Is your Mother/Parent A alive?**

- ( ) Yes
- ( ) No

*** Is your Father/Parent B alive?**

- Yes
- No

*** Are your parents divorced?**

- Yes
- No

*** Do you have step parents?**

- Yes
- No

*** Were you raised by someone other than your parents?**

- Yes
- No

*** Do you have siblings?**

- Yes
- No

*** Do you have step siblings?**

- Yes
- No

*** Please check as many as apply in your family of origin.**

- [ ] Family Alcoholism
- [ ] Domestic Violence
- [ ] Incest
- [ ] Rape
- [ ] Sexual Abuse

What else would you like me to know that would be helpful for me, as your therapist, to know about your experience growing up in your family?

RELIGIOUS/SPIRITUAL INFORMATION

*** Do you consider yourself to be religious?**

- [ ] Yes
- [ ] No

*** Do you consider yourself to be spiritual?**

- [ ] Yes
- [ ] No

*** Briefly describe your relationship with God/the Divine.**

*** Briefly describe your religious/spiritual upbringing.**

PRESENT SITUATION AND OTHER INFORMATION

*** What brings you to counseling/spiritual direction/consultation /coaching at this time? Is there something specific, such as a particular event? Be as detailed as you can.**

*** What would you like to experience that is different from what you are experiencing now?**

*** How long has this been a problem or concern for you?**

*** What do you consider to be your strengths?**

*** What do you like most about yourself?**

*** What are effective coping strategies that you've learned?**

*** What are your goals for counseling/spiritual direction/consultation /coaching?**

Thank you for investing in your own healing and taking the time to fill out this form.